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ABSTRACT

Task analyses are provided for two duty areas for the occupation of practical nurse (licensed practical nurse) in the nursing cluster. The two duty areas are: (1) providing therapeutic measures (30 tasks); and (2) performing diagnostic measures (14 tasks). Each task analysis consists of these components: occupation; duty area; tasks; performance standard; steps (procedure); knowledge; attitudes; safety; equipment and supplies; source of analysis; and list of Illinois State Goals for Learning. (YLB)

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Education
For
Employment
Task Lists

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1988

TASK ANALYSIS
FOR
HEALTH OCCUPATIONS

CLUSTER: NURSING

OCCUPATION: PRACTICAL NURSE (L.P.N.)

Duty Area: Providing Therapeutic Measures

CE 057 967

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"KEY TO EFFECTIVE LEARNING"

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TASK ANALYSIS
FOR
HEALTH OCCUPATIONS

CLUSTER:	**NURSING**
OCCUPATION:	**PRACTICAL NURSE (L.P.N.)**
Duty Area:	Providing Therapeutic Measures

TASK ANALYSIS

OCCUPATION	Practical Nurse (L.P.N.)
DUTY AREA	Providing Therapeutic Measures
TASK	Assist with removing, or remove, fecal impaction
PERFORMANCE STANDARD	Patient is examined for fecal impaction. All fecal blockage is removed and patient is cleansed. Treatment is reported and recorded.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Organize needed supplies.
6. Place patient in Sims' position.
7. Drape patient to protect privacy.
8. Place bedpan nearby.
9. Put on clean gloves.
10. Lubricate index finger.
11. Insert finger into the anal sphincter to inspect for fecal impaction.
12. Remove fecal pieces.
13. Determine if impaction is entirely removed, or if further intervention is needed.
14. Assist patient to use bedpan or to the bathroom to use stool.
15. Clean rectal area after treatment.
16. Remove gloves and place on paper towel.
17. Put away equipment and supplies.
18. Freshen air in patient's room.
19. Leave patient in comfortable and safe position.
20. Report and record treatment and results.

KNOWLEDGE

Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Place patient in Sims' position.
Identify advantages of water soluble lubricant.
Watch for signs of patient discomfort.
Describe the anal sphincter.
Describe fecal impaction and the implications for patient care.

KNOWLEDGE (Cont.)

Explain the signs and symptoms of a fecal impaction.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient while in hospital bed.
Cleanse and protect patient's skin.
Chart treatments using facility recording system.
Observe results of treatment.
Read and interpret physician's orders.
Read, interpret, contribute to, and implement nursing care plans.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Watch for signs of complications of procedure.
Discontinue treatment, and report any complications.

EQUIPMENT AND SUPPLIES

Disposable pad
Bedpan
Clean gloves
Lubricating jelly
Paper towel
Air freshener
Patient's chart
Patient's care plan

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 86.
Curriculum Models and Competencies, Associate Degree Nursing, North Carolina Department of Community Colleges, 1983.

ILLINOIS STATE GOALS FOR LEARNING	Physical Development and Health: Goal 1-A: Immediate and long-term effects of exercise and lack of exercise on the circulatory, respiratory and muscular systems of the body. Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Goal 2-F: Proper diet and changing balances in special conditions. Goal 2-K: Behaviors which promote self-esteem without being destructive to self or others. Goal 2-R: Signs and symptoms indicating the need for professional medical attention. Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease. Language Arts: Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting. Social Sciences: Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION	Practical Nurse (L.P.N.)
DUTY AREA	Providing Therapeutic Measures
TASK	Give enema
PERFORMANCE STANDARD	Patient evacuated bowel with desired results and is clean and dry. Treatment is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Organize needed supplies.
6. Position bed flat.
7. Instruct patient to empty bladder using bedpan, urinal, or commode as condition dictates, and assist if necessary.
8. Prepare solution to be administered.
   NOTE: Temperature should be approximately 40.5° C (105° F).
9. Run solution through tubing to remove air.
10. Place enema bag on standard 12-18 inches above patient.
11. Position underpad beneath patient's buttocks.
12. Position patient in Sims' position or on back with bedpan under buttocks and knees flexed as condition dictates.
13. Lubricate 1-2 inches of tip of enema tubing.
14. Put on gloves.
15. Spread patient's buttocks and insert tube, slowly and gently about 4 inches into rectum.
16. Release clamp and administer solution.
    NOTE: If patient experiences discomfort, stop flow and begin again at slower rate.
17. Clamp and remove tubing when patient can retain no more solution.
18. Wrap tubing in underpad.
19. Have patient take deep breaths to help retain solution.
20. Position patient on bedpan and tell patient to evacuate bowel or assist patient to bathroom to use toilet, as condition dictates.
21. Place toilet tissue and call button within reach.
22. Instruct patient to call for assistance when finished evacuating.
23. Assist patient to clean anal area.

STEPS
(Cont.)

24. Remove and cover bedpan, if used.
25. Note contents of bedpan or toilet before disposing of fecal material.
26. Assist patient in washing hands.
27. Replace soiled gown and bed linens if necessary.
28. Clean area.
29. Leave patient in comfortable and safe position.
30. Clean equipment and return to storage.
31. Wash hands.
32. Chart nursing care and characteristics of expelled material.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Place patient in Sims' position.
Identify various kinds of enemas that may be administered.
Give oil retention, cleansing and disposable enemas.
Explain the anatomy of the digestive tract and what the implications are for this treatment, i.e., enema.
Explain principle of gravity as it relates to this treatment, i.e., enema.
Identify advantages of water soluble lubricant.
Watch for signs of patient discomfort.
Describe the anal sphincter.
Assist patient to use bedpan.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient who is in hospital bed.
Cleanse and protect patient's skin.
Chart treatments using facility recording system.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY	Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Use thermometer to determine temperature of solutions. Use gentle touch during treatment as mucous membranes are easily injured. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it. Discontinue treatment, and report any complications.
EQUIPMENT AND SUPPLIES	Disposable pad Bedpan Clean gloves Lubricating jelly Paper towel Air freshener Patient's chart Bath thermometer Washcloth Soap and water Towels Toilet tissue Enema set Enema solution Standard Clean gown and linens, if needed
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 93.

ILLINOIS STATE GOALS FOR LEARNING

Biological and Physical Sciences:
- Goal 1-O: The nature of force.
- Goal 3-A: Ethical practices which include:
  - 3. rights of subjects, humanness and respect for life.
- Goal 4-A: Observation.
- Goal 4-F: Communication.

Language Arts:
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.

Mathematics:
- Goal 3-E: Application of selected measurement systems, instruments, and techniques.

Physical Development and Health:
- Goal 1-A: Immediate and long-term effects of exercise and lack of exercise on the circulatory, respiratory and muscular systems of the body.
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-F: Proper diet and changing balances in special conditions.
- Goal 2-K: Behaviors which promote self-esteem without being destructive to self or others.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Social Sciences:
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Insert rectal tube

PERFORMANCE STANDARD Rectal tube is inserted. Procedure is charted as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment.
6. Provide privacy.
7. Position patient on side with one knee flexed.
8. Put on clean gloves.
9. Lubricate rectal tube.
10. Encourage patient to take deep breaths as tube is inserted.
11. Insert tube about 4 inches.
12. Wrap free end of tube in towel.
13. Remove tube in 30 minutes or less.
14. Clean patient's rectal area.
15. Freshen air in patient's room, if necessary.
16. Clean and put away equipment and supplies.
17. Leave patient in comfortable and safe position.
18. Wash hands.
19. Report and record treatment and results.

KNOWLEDGE

Read and interpret assignment sheet.
Read and interpret doctor's orders.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Identify rectal tube.
Explain how a rectal tube can release flatus.
Explain how this procedure can make a patient more comfortable.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.

KNOWLEDGE (Cont.)

Explain the anatomy of the digestive tract and what the implications are for this treatment, i.e., insert rectal tube.
Explain the complications of prolonged treatment.
Identify advantages of water soluble lubricant.
Watch for signs of patient discomfort.
Describe the anal sphincter.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient in hospital bed.
Cleanse and protect patient's skin.
Chart treatments using facility recording system.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Use gentle touch during treatment as mucous membranes are easily injured.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment, and report any complications.

EQUIPMENT AND SUPPLIES

Rectal tube
Towels
Washcloth
Soap and water
Clean gloves
Lubricating jelly
Paper towel
Air freshener
Patient's chart

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 65.
Nursing Skills for Allied Health Services, Wood and Rambo, W. B. Saunders Company, 1977.

ILLINOIS STATE GOALS FOR LEARNING

Biological and Physical Sciences:
- Goal 1-O: The nature of force.
- Goal 3-A: Ethical practices which include:
  - 3. rights of subjects, humanness and respect for life.
- Goal 4-A: Observation.
- Goal 4-F: Communication.

Language Arts:
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.

Physical Development and Health:
- Goal 1-A: Immediate and long-term effects of exercise and lack of exercise on the circulatory, respiratory and muscular systems of the body.
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-F: Proper diet and changing balances in special conditions.
- Goal 2-K: Behaviors which promote self-esteem without being destructive to self or others.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

Social Sciences:
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION	Practical Nurse (L.P.N.)
DUTY AREA	Providing Therapeutic Measures
TASK	Irrigate colostomy
PERFORMANCE STANDARD	Colon is emptied of fecal matter. Solution is administered with no solution remaining in colon. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure.
4. Wash hands.
5. Assemble equipment at bedside or in the bathroom.
6. Connect irrigation cone or catheter to tubing of irrigation bag.
7. Fill irrigation bag with solution as ordered.
   NOTE: Temperature should be approximately 40.5° C (105° F).
8. Allow solution to run through tubing to remove air.
9. Clamp tubing.
10. Hang irrigation bag on standard.
    NOTE: Level of bag should not be more than 18-20 inches above stoma.
11. Provide privacy.
    If patient is in bed:
12. Assist patient to turn toward side from which colostomy will drain.
13. Place disposable underpad under patient near colostomy opening.
14. Place bedpan directly under stoma.
    If patient is in bathroom:
15. Assist patient to sit on toilet so that colostomy can drain into toilet.
16. Put on disposable gloves.
17. Remove soiled dressing and/or stoma pouch.
18. Discard soiled dressing in disposable bag.
19. Measure excreta in bag and discard.
20. Cleanse area around stoma with soap and water.
21. Remove and discard gloves.
22. Put on fresh gloves.
23. Lubricate rectal tip.
24. Insert rectal tip into colostomy stoma and hold catheter securely to prevent backsplash and trauma.
    CAUTION: DO NOT FORCE TIP INTO STOMA.
25. Unclamp tubing and allow solution to run in slowly.

STEPS
(Cont.)

26. Clamp tubing.
27. Remove rectal tube.
28. Instruct patient to remain on side (or on toilet with irrigator drain bag in place) until all solution has returned.
29. Remove bedpan and discard contents (or flush toilet).
30. Remove and discard gloves.
31. Wash hands.
32. Cleanse area around stoma.
33. Apply skin prep as ordered.
34. Apply dressing or drainage bag.
35. Clean and put away equipment and supplies.
36. Leave patient in a safe and comfortable position.
37. Wash hands.
38. Chart treatment and results.

KNOWLEDGE

Read and interpret assignment sheet.
Read and interpret doctor's orders.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Explain the anatomy of the digestive tract and what the implications are for this treatment, i.e., colostomy irrigation.
Explain reason for colostomy.
Explain different types of colostomies and the appearance of each.
Use ostomy supplies.
Apply colostomy bag or irrigating drain.
Explain principle of gravity as it relates to this treatment, i.e., colostomy irrigation.
Identify advantages of water soluble lubricant.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient who is in hospital bed.
Cleanse and protect patient's skin.
Explain special needs for skin care which is exposed to chemicals, adhesives and feces.
Encourage patient in self care as appropriate.
Chart treatments using facility recording system.
Use observation skills to assess results of irrigation.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.

ATTITUDES (Cont.)

Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Accept responsibility to do even distasteful nursing tasks thoroughly.
Empathize with patient's feelings of altered body image.
Accept patient's embarrassment or squeamishness at seeing feces in colostomy bag.
Recognize importance of teaching patient acceptance and independence.
Accept possibility of patient's initial feelings of being overwhelmed and unwilling to care for self.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Use thermometer to determine temperature of solutions.
Use gentle touch during treatment as mucous membranes are easily injured.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Avoid excessive fluid pressure by holding container with solution at the best height to control instillation.
Discontinue treatment, and report any complications.

EQUIPMENT AND SUPPLIES

Bedpan with cover or toilet
Clamp
Disposable bag
Disposable enema tray with small rubber rectal tube
Disposable gloves
Disposable underpad (for bed patient)
Drainage bag or dressing
Irrigation bag
Irrigation cone or catheter
Standard
Patient's chart
Prescribed solution
Bath thermometer
Skin prep
Soap pads
Stoma pouch

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 130.

Curriculum Models and Competencies, Associate Degree Nursing, North Carolina Department of Community Colleges, 1983.

ILLINOIS STATE GOALS FOR LEARNING

Biological and Physical Sciences:
- Goal 1-O: The nature of force.
- Goal 3-A: Ethical practices which include:
  - 3. rights of subjects, humanness and respect for life.
- Goal 4-A: Observation.
- Goal 4-F: Communication.

Language Arts:
- Goal 2-F: Effective and appropriate responses.
- Goal 2-D: Distinction among different purposes in communication.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Mathematics:
- Goal 3-E: Application of selected measurement systems, instruments, and techniques.

Physical Development and Health:
- Goal 1-A: Immediate and long-term effects of exercise and lack of exercise on the circulatory, respiratory and muscular systems of the body.
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-F: Proper diet and changing balances in special conditions.
- Goal 2-K: Behaviors which promote self-esteem without being destructive to self or others.
- Goal 2-M: Development of positive self-concept and how it relates to physical and emotional variations and interpersonal relationships.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Social Sciences:
- Goal 3-B: Selected principles of learning and motivation.
- Goal 3-C: Selected relationships between personality and development.
- Goal 3-E: Common support networks in contemporary society.
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply cold compress

PERFORMANCE STANDARD Bed linens and patient are dry. Cold compress covers the designated area and remains in place the prescribed length of time. The treatment and results are recorded and reported as required.

STEPS

1. Receive assignment.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Organize needed supplies and equipment.
6. Position patient in appropriate position depending upon where the compress is to be applied.
7. Place cold solution in basin.
8. Provide privacy for patient.
9. Protect bed linen during treatment with plastic sheet or disposable pad.
10. Moisten compress in solution.
11. Apply compress to area to receive treatment.
12. Check pulses in area of treatment.
13. Keep compress cold by changing compress every 2-3 minutes or by applying plastic with an ice bag over compress.
14. Check area frequently for blueness or paleness.
15. Continue treatment for the specified period of time.
16. Dry patient after the treatment.
17. Clean and return equipment to storage.
18. Leave patient in comfortable, safe position.
19. Report and record treatment and results.

KNOWLEDGE

Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.

KNOWLEDGE (Cont.)	Use medical terminology to communicate with other health care workers. Make hospital bed, occupied or unoccupied. Move and turn patient who is in hospital bed. Cleanse and protect patient's skin. Chart treatments using facility recording system. Observe results of treatment. Explain the effects of cold on the skin and body. Find pulse points of the body. Apply an ice bag. Time treatments as prescribed.
ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. In addition, refer to Employability Skills List.
SAFETY	Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Use thermometer to determine temperature of solutions. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it. Discontinue treatment and report any complications.
EQUIPMENT AND SUPPLIES	Basin Ice Plastic sheet(s) or disposable pad Solution as prescribed Ice bag Towel(s)
SOURCE OF ANALYSIS	V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 48.

ILLINOIS
STATE GOALS
FOR
LEARNING

Physical Development and Health:
- Goal 1-A: Immediate and long-term effects of exercise and lack of exercise on the circulatory, respiratory and muscular systems of the body.
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-D: Sensitivity to difficulties of the text, requirements of the task, abilities and motivation.
- Goal 2-A: Meaning of spoken messages.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Administer hot soak

PERFORMANCE STANDARD Designated area is immersed the prescribed period of time in the prescribed solution without burning the patient. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment.
6. Place patient in position for procedure.
7. Protect bed linen during treatment with plastic sheet or disposable pad.
8. Fill basin one-half full with solution as ordered.
9. Lower the part of the patient's body slowly into the solution.
10. Cover the treatment area to conserve heat.
11. Add more solution to maintain the temperature of the solution.
    NOTE: Remove the body part from the basin while adding solution.
12. Check the patient's skin during treatment for reaction to heat.
13. Pat patient's skin dry.
14. Clean and store equipment.
15. Assist patient to a safe, comfortable position.
16. Chart treatment and results as required.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.

KNOWLEDGE (Cont.)	Use medical terminology to communicate with other health care workers. Make hospital bed, occupied or unoccupied. Move and turn patient who is in hospital bed. Cleanse and protect patient's skin. Chart treatments using facility recording system. Observe results of treatment. Determine the temperature of solution using a bath thermometer. Explain the reaction of the skin to heat therapy.
ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. Respect the patient's right to know about, and participate in treatment. In addition, refer to Employability Skills List.
SAFETY	Explain safe temperature of solution which is to be in contact with patient's skin. Prevent the spread of infection to patients, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Use thermometer to determine temperature of solutions. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it. Discontinue treatment and report any complications.
EQUIPMENT AND SUPPLIES	Basin Plastic sheet Solution as prescribed Bath thermometer Towels
SOURCE OF ANALYSIS	V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 49.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-A: Immediate and long-term effects of exercise and lack of exercise on the circulatory, respiratory and muscular systems of the body.
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-D: Sensitivity to difficulties of the text, requirements of the task, abilities and motivation.
- Goal 2-A: Meaning of spoken messages.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Administer sitz bath

PERFORMANCE STANDARD Water temperature is prepared and maintained. Patient is assisted into and out of tub safely. The sitz bath is continued for the designated time unless the patient experiences faintness.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Organize equipment and supplies.
6. Fill tub 1/3-1/2 full of water.
7. Ask patient to void.
8. Check the temperature of the water (100^0-110^0F or 39^0-44^0C).
9. Assist patient into tub.
10. Time the sitz bath as directed.
11. Add water to maintain temperature.
    NOTE: To avoid the danger of scalding, add hot water away from patient.
12. Observe patient for faintness.
13. Assist patient from tub.
14. Assist patient in drying.
15. Accompany patient back to room.
16. Clean tub.
17. Remove soiled linens and equipment.
18. Chart treatment and results as required.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Cleanse and protect patient's skin.

KNOWLEDGE (Cont.)	Chart treatments using facility recording system. Observe results of treatment. Determine the temperature of solution using a bath thermometer. Explain the reaction of the skin to heat therapy. Time treatments as prescribed. Recognize faintness.
ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. Respect the patient's right to know about and participate in treatment. In addition, refer to Employability Skills List.
SAFETY	Explain safe temperature of solution which is to be in contact with patient's skin. Prevent the spread of infection to patients, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Use thermometer to determine temperature of solutions. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Place call light where patient can easily reach it. Discontinue treatment and report any complications. Maintain temperature of water by adding hot water to tub a safe distance away from the patient.
EQUIPMENT AND SUPPLIES	Towels Bath thermometer Sitz tub or bathtub
SOURCE OF ANALYSIS	V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 50.
ILLINOIS STATE GOALS FOR LEARNING	Physical Development and Health: Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Language Arts:

- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-D: Sensitivity to difficulties of the text, requirements of the task, abilities and motivation.
- Goal 2-A: Meaning of spoken messages.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION	Practical Nurse (L.P.N.)
DUTY AREA	Providing Therapeutic Measures
TASK	Apply heat lamp
PERFORMANCE STANDARD	Heat lamp is directed to prescribed area. The time prescribed for the treatment is observed. The lamp is positioned approximately 18 inches from skin.
STEPS	1. Verify order. 2. Identify patient. 3. Explain procedure to patient. 4. Wash hands. 5. Assemble equipment. 6. Provide privacy. 7. Place patient in position for procedure. 8. Expose only the part of the body to be treated. 9. Direct heat of the lamp to designated skin area. 10. Check the patient's skin during treatment for reaction to heat. 11. Continue treatment as long as directed. 12. Store equipment. 13. Assist patient to a safe, comfortable position. 14. Chart treatment and results as required.
KNOWLEDGE	Read and interpret doctor's orders. Read and interpret assignment sheet. Read and interpret patient care plan. Use facility procedure for positively identifying patient. Wash hands aseptically. Use communication skills to explain procedures to patient and family. Use aseptic technique. Organize needed supplies. Operate hospital bed. Position patient for treatment. Watch for signs of patient discomfort. Use medical terminology to communicate with other health care workers. Make hospital bed, occupied or unoccupied. Move and turn patient who is in hospital bed. Cleanse and protect patient's skin. Chart treatments using facility recording system.

KNOWLEDGE (Cont.)	Observe results of treatment. Explain the reaction of the skin to heat therapy. Time treatment as prescribed. Estimate the measurement of eighteen inches.
ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. Respect the patient's right to know about and participate in treatment. Accept responsibility to assure that patient does not suffer a burn from treatment. In addition, refer to Employability Skills List.
SAFETY	Prevent the spread of infection to patients, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Place call light where patient can easily reach it. Discontinue treatment and report any complications. Check on patient often and regularly during treatment to prevent burns. Use safety items as intended, i.e., shield over lamp bulb, three-pronged plug. NOTE: DO NOT BYPASS SAFETY PRECAUTIONS.
EQUIPMENT AND SUPPLIES	Heat lamp
SOURCE OF ANALYSIS	V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 52.
ILLINOIS STATE GOALS FOR LEARNING	Physical Development and Health: Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

ILLINOIS
STATE GOALS
FOR
LEARNING
(Cont.)

Language Arts:

- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-D: Sensitivity to difficulties of the text, requirements of the task, abilities and motivation.
- Goal 2-A: Meaning of spoken messages.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Mathematics:

- Goal 3-B: Estimation of measurements.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply warm compress

PERFORMANCE STANDARD Moist heat is applied to selected area for designated time. Patient's skin is monitored during treatment. Procedure is charted and reported as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment.
6. Place patient in position for procedure.
7. Protect bed linen during treatment with plastic sheet or disposable pad.
8. Lubricate skin around area to be treated using petroleum jelly.
9. Check temperature of solution with solution thermometer. NOTE: Temperature should not exceed 115°-120°F or 47°-49°C.
10. Dip compresses in solution; wring out; apply to area to be treated.
11. Cover with plastic wrap or towel to maintain heat.
12. Continue treatment as long as directed.
13. Reheat compresses by dipping again.
14. Check area frequently for signs of redness.
15. Wash off petroleum jelly after completion of treatment.
16. Dry patient.
17. Clean and replace equipment.
18. Assist patient to a safe, comfortable position.
19. Chart treatment and results as required.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.

KNOWLEDGE (Cont.)

Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient who is in hospital bed.
Cleanse and protect patient's skin.
Time procedure.
Chart treatments using facility recording system.
Explain the effect of heat on the skin.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
In addition, refer to Employability Skills List.

SAFETY

Explain safe temperature of solution which is to be in contact with patient's skin.
Prevent the spread of infection to patients, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Use thermometer to determine temperature of solutions.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Basin
Compresses
Petroleum jelly
Protective plastic sheet or disposable pad
Plastic wrap
Towels
Bath thermometer
Solution

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 60.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:

- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Language Arts:

- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-D: Sensitivity to difficulties of the text, requirements of the task, abilities and motivation.
- Goal 2-A: Meaning of spoken messages.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply aquamatic pad

PERFORMANCE STANDARD Aquamatic unit is filled 2/3 full with distilled water. Patient is not wet, burned or in discomfort from heat application. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment.
6. Place patient in position for procedure.
7. Provide privacy.
8. Inspect area to receive treatment.
9. Fill aquamatic unit with distilled water until 2/3 full.
10. Remove air bubbles and secure top.

For moist application:

11. Place wet side of pad on area to receive treatment.

For dry application:

12. Place dry side of pad on area to receive treatment.
13. Instruct patient to summon nurse if discomfort is experienced.
14. Place call button within patient's reach.
15. Return and check skin condition frequently.
16. Check water level once each shift and fill with distilled water.
17. Leave patient in safe and comfortable position.
18. Clean area and return equipment to storage.
19. Record and report treatment as required.

KNOWLEDGE

Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.

KNOWLEDGE (Cont.)

Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient who is in hospital bed.
Cleanse and protect patient's skin.
Chart treatments using facility recording system.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
Treat expensive equipment with care and according to instructions.
In addition, refer to Employability Skills List.

SAFETY

Explain safe temperature of items which are to be in contact with patient's skin.
Prevent the spread of infection to patients, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call button where patient can easily reach it.
Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Aquamatic pad and unit
Distilled water

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 65.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

ILLINOIS
STATE GOALS
FOR
LEARNING
(Cont.)

Language Arts:

Goal 1-A: Recognition, recall, and summarization of material read.

Goal 1-D: Sensitivity to difficulties of the text, requirements of the task, abilities and motivation.

Goal 2-A: Meaning of spoken messages.

Goal 4-A: Clear and expressive speaking.

Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.

Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply ice bag

PERFORMANCE STANDARD Ice bag is securely applied to selected area for designated time. Patient's skin is monitored during treatment. Procedures are recorded and reported as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Organize needed supplies and equipment.
6. Position patient in appropriate position depending upon where the ice bag is to be applied.
7. Inspect area to be treated.
8. Fill ice bag 3/4 full.
9. Remove excess air.
10. Protect patient and bed linen with plastic sheet or disposable pad.
11. Place a cover between the ice bag and the patient.
12. Apply ice bag to area to receive treatment.
13. Check area frequently for blueness or paleness and for tingling and loss of sensation.
14. Continue treatment for the specified period of time.
15. Empty, clean and return equipment to storage.
16. Leave patient in comfortable, safe position.
17. Report and record treatment and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.

KNOWLEDGE (Cont.)

Move and turn patient who is in hospital bed.
Cleanse and protect patient's skin.
Chart treatments using facility recording system.
Observe results of treatment.
Explain the effects of cold on the skin and body.
Time treatments as prescribed.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Ice bag
Protective cover
Ice
Plastic sheet or disposable pad

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 57.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-D: Sensitivity to difficulties of the text, requirements of the task, abilities and motivation.
- Goal 2-A: Meaning of spoken messages.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Assist with whirlpool treatment

PERFORMANCE STANDARD Patient is provided with whirlpool bath as ordered. Patient is assisted with transportation to and from bath area and assisted with bath as required, whirlpool bath is correctly adjusted and water temperature is maintained at 105°. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy.
7. Transport or accompany patient to bath area, providing robe, slippers, blanket and wheelchair, if needed.
8. Adjust whirlpool action.
9. Monitor temperature of water.
10. Place "Occupied" sign on door.
11. Assist patient with undressing.
12. Assist patient into tub.
13. Remain with patient or return at intervals.
14. Assist patient from tub and provide towel.
15. Assist patient with dressing as needed.
16. Return patient to room and assist with removing robe and slippers.
17. Assist patient into bed.
18. Leave patient in comfortable, safe position.
19. Clean whirlpool bath area.
20. Report and record treatment as required.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.

KNOWLEDGE (Cont.)

Transport patient in wheelchair.
Transfer patient from bed to wheelchair, and from wheelchair to bed.
Use thermometer to determine the temperature of water.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient who is in hospital bed.
Cleanse and protect patient's skin.
Record treatments using facility recording system.
Report observations and treatments according to facility reporting procedures.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
In addition, refer to Employability Skills List.

SAFETY

Explain safe temperature of solution which is to be in contact with patient's skin.
Prevent the spread of infection to patients, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Use thermometer to determine temperature of solutions.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Towel
Washcloth
Soap
Whirlpool bath
Wheelchair, if needed
OCCUPIED sign

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 115.

ILLINOIS STATE GOALS FOR LEARNING

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 6-D: English grammar.

Mathematics:
- Goal 3-A: Measurement in various contexts using appropriate units.

Biological and Physical Sciences:
- Goal 4-A: Observation.
- Goal 4-F: Communication.

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Administer tepid bath

PERFORMANCE STANDARD Patient's temperature is taken before and after bath. Bath water is 86°F and treatment lasts 15 minutes. Procedure is reported and recorded as required.

STEPS

1. Check physician's order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Take patient's temperature.
7. Assist patient to tub room if body temperature is normal or according to assignment.
8. Draw water.
   NOTE: Temperature of water should be 86°F (30°C).
9. Provide privacy.
10. Eliminate drafts.
11. Assist patient in undressing.
12. Assist patient into tub.
13. Sit with patient during 15 minute treatment if necessary.
14. Assist patient to dry.
15. Assist patient in dressing.
16. Assist patient back to bed.
17. Take patient's temperature.
18. Leave patient in safe, comfortable position.
19. Wash hands.
20. Report and record treatment as required.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.

KNOWLEDGE (Cont.)

Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Transport patient using wheelchair.
Take patient's temperature.
Determine the temperature of water using thermometer.
Cleanse and protect patient's skin.
Chart treatments using facility recording system.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
In addition, refer to Employability Skills List.

SAFETY

Explain safe temperature of solution which is to be in contact with patient's skin.
Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Use thermometer to determine temperature of solutions.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Bath thermometer
Thermometer
Towels
Bathtub

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 63.

ILLINOIS STATE GOALS FOR LEARNING

Mathematics:
- Goal 3-A: Measurement in various contexts using appropriate units.
- Goal 7-D: Ability to determine whether an estimate is a better alternative than an exact value.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Physical Development and Health:

- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

Language Arts:

- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:

- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply electric hypothermal blanket

PERFORMANCE STANDARD Hypothermal blanket is free of defects and kinks in tubing. Machine is placed in cool, unobstructed area. Patient's temperature and skin color are monitored for changes. Blanket is applied next to patient's skin, one pad under the patient and one pad over the patient. Machine is operated according to facility procedure. Procedure is reported and recorded as required.

STEPS

1. Verify physician's order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment.
6. Check equipment for defects.
7. Remove kinks in tubing.
8. Place machine in cool, unobstructed area.
9. Connect K-pad to machine.
10. Connect probe to machine.
11. Plug in machine.
12. Fill reservoir with prescribed solution.
13. Set dial to prescribed temperature.
14. Recheck fluid level after 2-3 minutes.
15. Position patient with the help of one additional staff member in order to apply K-pad to bedding.
16. Position one body-size pad under patient so pad comes in contact with patient's skin.
17. Remove patient's gown.
18. Place second body-size pad on top of patient.
19. Insert probe into patient's rectum.
20. Tape probe in place.
21. Set automatic cool-heat button on machine.
22. Take patient's temperature.
23. Retake patient's temperature frequently.
24. Check patient's skin color.
25. Report and record abnormal temperature and skin color changes.
26. Provide for patient's comfort during treatment.
27. Wash hands.
28. Record and report information as required.

KNOWLEDGE

Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient who is in hospital bed.
Cleanse and protect patient's skin.
Take patient's temperature.
Insert rectal probe.
Explain normal body temperature ranges.
Explain normal appearance of skin.
Explain appearance of skin as affected by abnormal body temperature.
Chart treatments using facility recording system.
Observe results of treatment.
Use hypothermal blanket and machine.
Use facility system to record and report treatments.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
Accept the fact that a patient who is seemingly unconscious may be able to hear conversation going on around them.
Treat expensive equipment with care.
In addition, refer to Employability Skills List.

SAFETY

Explain safe temperature of item which is to be in contact with patient's skin.
Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it even though the patient is seemingly unconscious.

SAFETY (Cont.)	Discontinue treatment and report any complications. Use caution in handling K-pads as the tubing can be punctured with sharp items, such as safety pins. Use caution when inserting probe into patient's rectum as mucous membranes are easily injured.
EQUIPMENT AND SUPPLIES	Tape Hypothermal K-pads Hypothermal machine Reservoir solution Thermometer Additional staff person
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 69.
ILLINOIS STATE GOALS FOR LEARNING	Physical Development and Health: Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Goal 2-R: Signs and symptoms indicating the need for professional medical attention. Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease. Mathematics: Goal 3-A: Measurement in various contexts using appropriate units. Language Arts: Goal 1-A: Recognition, recall, and summarization of material read. Goal 2-A: Meaning of spoken messages. Goal 2-C: Inferences from spoken messages and nonverbal cues. Goal 2-F: Effective and appropriate responses. Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences. Goal 4-A: Clear and expressive speaking. Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting. Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Assist with dressing change

PERFORMANCE STANDARD Equipment and supplies for dressing change are placed where they are convenient for use. Supplies and equipment are safe for use. Nurse or physician are assisted as needed. Waste is disposed of according to facility procedures. Procedure is recorded and reported as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment including dressing tray, sterile gloves, adhesive or nonallergic tape, plastic bag, basin or waste can.
6. Check autoclave indicator and date on all equipment and supplies.
7. Place equipment and supplies where they will be convenient for use.
8. Provide privacy for patient.
9. Tear off tape that will be needed for dressing change and place it where it will be available for use.

When nurse or physician is ready:

10. Assist as needed.

When dressing change is completed:

11. Leave patient in safe, comfortable position.
12. Clean and replace all equipment used.
13. Dispose of all waste according to facility procedure.
14. Wash hands.
15. Report and record procedure as required.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Explain transmission of microorganisms.
Recognize sterile surfaces and contaminated surfaces.
Maintain a sterile field.

KNOWLEDGE (Cont.)

Use "drop" or "mitten" techniques to transfer items into sterile field.
Use pickup forceps.
Use sterile gloves.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Describe the changing of a dressing.
Make hospital bed, occupied or unoccupied.
Use facility system in reporting and recording treatments.
Observe results of treatment.
Interpret autoclave indicators.
Use infection control procedures to dispose of waste.

ATTITUDES

Recognize the danger to patient, staff, and families if careless regarding contamination of sterile field or disposal of contaminated dressings.
Anticipate what the person being assisted will need during the procedure.
Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment and report any complications.
Use facility infection control procedures to dispose of waste.

EQUIPMENT AND SUPPLIES

Pickup forceps
Sterile dressing tray
Sterile gloves
Adhesive or nonallergic tape
Plastic bag, basin or waste can

SOURCE OF ANALYSIS

Diversified Health Occupations, Louise Simmers, 1983, pp. 75-85.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply clean dressing

PERFORMANCE STANDARD Dressing is applied as ordered. Observations and treatment are reported and recorded as required. Old dressings are disposed of according to facility procedures.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Place equipment and supplies where they will be convenient.
7. Provide privacy for patient.
8. Position patient for treatment.
9. Remove soiled dressing.
10. Note characteristics of area being dressed and drainage on old dressing.
11. Wash and dry wound to be dressed.
12. Apply dressing as ordered.
13. Secure dressing using tape, metal clips, or safety pins, as ordered.
14. Leave patient in safe, comfortable position.
15. Clean area disposing of all waste according to facility procedure.
16. Put equipment and supplies away.
17. Wash hands.
18. Report and record procedure as required.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Explain transmission of microorganisms.
Apply bandages.
Organize needed supplies.
Operate hospital bed.

KNOWLEDGE (Cont.)

Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Cleanse and protect patient's skin.
Use facility system in reporting and recording treatments.
Observe results of treatment.
Use infection control procedures to dispose of waste.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Nonsterile dressing
Soap or other cleansing agent, as ordered
Tape, metal clips or safety pins

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 97.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

ILLINOIS
STATE GOALS
FOR
LEARNING
(Cont.)

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply elastic bandage

PERFORMANCE STANDARD Elastic bandages are applied as ordered. Bandages completely cover intended area and fit snugly and smoothly but do not impede circulation. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Remove bedcovers and expose patient's feet and legs.
7. Position extremity to be wrapped at same level as heart.
8. Wrap bandage from distal to proximal part of extremity.
9. Anchor bandage at beginning.
10. Apply bandage with firm, even pressure, avoiding wrinkles.
11. Wrap bandage so that area is completely covered.
12. Anchor end of bandage.
13. Check pulse or observe skin color to determine that circulation is adequate.
14. Leave patient in safe, comfortable position.
15. Report and record treatment as required.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Recognize signs and symptoms of impeded circulation.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.

KNOWLEDGE (Cont.)	Make hospital bed, occupied or unoccupied. Use facility system in reporting and recording treatments. Observe results of treatment.
ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. Respect the patient's right to know about and participate in treatment. In addition, refer to Employability Skills List.
SAFETY	Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it. Discontinue treatment and report any complications.
EQUIPMENT AND SUPPLIES	Elastic bandages
SOURCE OF ANALYSIS	V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 93.
ILLINOIS STATE GOALS FOR LEARNING	Physical Development and Health: Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)	Language Arts: Goal 1-A: Recognition, recall, and summarization of material read. Goal 2-A: Meaning of spoken messages. Goal 2-C: Inferences from spoken messages and nonverbal cues. Goal 2-F: Effective and appropriate responses. Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences. Goal 4-A: Clear and expressive speaking. Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting. Goal 6-D: English grammar. Social Sciences: Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply binder

PERFORMANCE STANDARD Area to which binder is applied is clean and dry. Binder is wrapped tightly but does not cut off circulation. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Measure area to which binder will be applied.
6. Order binder indicated by measurement.
7. Assemble supplies.
8. Provide privacy.
9. Position patient for treatment.
10. Wash and dry area to be wrapped.
11. Apply binder, pulling very tightly.
12. Fasten lower edge to Velcro.
13. Continue fastening up the Velcro strip.
14. Leave patient in safe, comfortable position.
15. Wash hands.
16. Report and record procedure.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Measure using tape measure.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Cleanse and protect patient's skin.
Use facility system in reporting and recording treatments.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment and report any complications.
Check patient at intervals to see that circulation isn't impeded.

EQUIPMENT AND SUPPLIES

Velcro binder
Tape measure
Soap and water
Washcloth
Towel

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 106.

ILLINOIS STATE GOALS FOR LEARNING

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Physical Development and Health:

- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Mathematics:

- Goal 3-A: Measurement in various contexts using appropriate units.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Connect nasogastric tube to suction machine

PERFORMANCE STANDARD Nasogastric tube is in stomach and is patent. Tubing is securely taped to patient's nose and is attached to patient's gown. Machine is suctioning patient. Procedure is recorded on patient's chart.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment.
6. Provide privacy.
7. Check position of nasogastric tube.
   NOTE: Nasogastric tube must be reinserted if not in position.
8. Connect extension tubing to nasogastric tube.
9. Test suction machine.
   NOTE: Replace faulty equipment if necessary.
10. Clear vent of vented tubing.
11. Plug in and turn on machine.
12. Adjust amount of suction.
13. Note drainage.
14. Leave patient in safe, comfortable position.
15. Report and record procedure including characteristics and amount of drainage.

KNOWLEDGE

Explain diagnosis and condition of patient and the reason for nasogastric suction.
Verify treatment type, equipment, site, duration and frequency.
Explain effects and value of treatment to patient.
Read and interpret doctor's orders.
Read and interpret assignment sheet.
Implement, read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Explain various types of nasogastric tubes.

KNOWLEDGE (Cont.)

Insert gastric tube for drainage purposes.
Irrigate nasogastric tube.
Explain continuous and intermittent suction.
Use various types of suction apparatus.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Use facility system in reporting and recording treatments.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY

Check suction apparatus at regular intervals to be certain drainage bottles do not overflow and damage the apparatus.
Accept the fact that if the nasogastric tube is not properly positioned in the patient's stomach, aspiration can occur causing pneumonia or even death.
Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Irrigation tray
Nasogastric tube
Stethoscope
Suction machine

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 91.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:

- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Biological and Physical Sciences:

- Goal 1-N: Relationship of structure to function.

Language Arts:

- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:

- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Assist physician in performing therapeutic procedure

PERFORMANCE STANDARD Patient is prepared for procedure. Physician is provided with required assistance, equipment and supplies. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy.
7. Position patient for procedure.
8. Open equipment and supplies as needed.
9. Hand equipment and/or supplies to physician as needed.
10. Hold patient, if needed, during procedure.
11. Provide support and reassurance to patient during procedure.
12. Leave patient in a safe, comfortable position.
13. Clean or dispose of equipment and supplies after procedure.
14. Wash hands.
15. Report and record procedure.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Use facility system in reporting and recording treatments.
Observe results of treatment.
Determine equipment and supplies needed for treatment.

ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. Respect the patient's right to know about and participate in treatment. Accept responsibility to do even distasteful nursing tasks thoroughly. In addition, refer to Employability Skills List.
SAFETY	Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it.
EQUIPMENT AND SUPPLIES	Equipment and supplies for procedure
SOURCE OF ANALYSIS	Curriculum Models and Competencies, Associate Degree Nursing, North Carolina Department of Community Colleges, 1983.
ILLINOIS STATE GOALS FOR LEARNING	Language Arts: Goal 1-A: Recognition, recall, and summarization of material read. Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose. Goal 2-A: Meaning of spoken messages. Goal 2-C: Inferences from spoken messages and nonverbal cues. Goal 2-F: Effective and appropriate responses. Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences. Goal 4-A: Clear and expressive speaking. Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting. Goal 6-D: English grammar. Physical Development and Health: Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Social Sciences: Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Set up croup tent

PERFORMANCE STANDARD Croup tent covers patient from head to waist and mist is flowing at prescribed rate. NO SMOKING signs are posted on door and above patient's bed. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Identify patient.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment.
6. Check equipment for defective parts and replace if necessary.
7. Plug compressor compartment into grounded outlet.
8. Turn switch to cool.
9. Raise canopy support rod to horizontal position.
10. Raise canopy over rod.
11. Stretch opening in canopy around evaporation shroud to tent.
12. Place canopy sides under mattress.
13. Turn on oxygen source to prescribed flow.
14. Post NO SMOKING signs in place over bed and on door.
15. Observe patient for change in consciousness level, abnormal color, perspiration, change in blood pressure, and increasing heart rate and temperature.
    NOTE: Report changes to nurse in charge.
16. Leave patient in safe, comfortable position.
17. Wash hands.
18. Report and record procedure.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Explain the mechanism of the croup tent.
Operate hospital bed.

KNOWLEDGE (Cont.)	Position patient for treatment. Watch for signs of patient discomfort. Use medical terminology to communicate with other health care workers. Make hospital bed, occupied or unoccupied. Move and turn patient who is in hospital bed. Take patient's temperature. Explain normal body temperature ranges. Explain normal appearance of skin, including color and perspiration rate. Explain appearance of skin as affected by abnormal body temperature. Take blood pressure. Take pulse. Observe level of consciousness. Observe results of treatment. Use facility system to record and report treatments.
ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. Respect the patient's right to know about and participate in treatment. Accept patient's feelings of fear of being "closed in" which may be heightened by an inability to breathe normally. In addition, refer to Employability Skills List.
SAFETY	Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it even though the patient is seemingly unconscious. Use no electrical equipment inside tent because of the combustibility of oxygen.
EQUIPMENT AND SUPPLIES	Compressor compartment NO SMOKING signs Oxygen tent Oxygen wall outlet or cylinder
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 116.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-J: Healthy and unhealthy responses to stress and their relationship to physical and mental illness.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Set up vaporizer

PERFORMANCE STANDARD Vaporizer contains sterile water and is operating with mist directed toward patient. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Check vaporizer for defective parts and replace, if necessary.
7. Pour sterile water into vaporizer to "fill" line.
8. Place vaporizer on bedside table.
9. Plug vaporizer into grounded outlet.
10. Turn vaporizer on.
11. Turn mist outlet toward patient.
12. Check water level each shift.
13. Clean and put away equipment and supplies not in use.
14. Leave patient in a safe and comfortable position.
15. Wash hands.
16. Record and report treatment and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Move and turn patient who is in hospital bed.
Observe results of treatment.
Use facility system to record and report treatments.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it even though the patient is seemingly unconscious.
Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Sterile water
Vaporizer

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 117.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
  Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
  Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
Social Sciences:
  Goal 3-F: Development of oral and written communication.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Language Arts:

Goal 1-A: Recognition, recall, and summarization of material read.

Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.

Goal 2-A: Meaning of spoken messages.

Goal 2-C: Inferences from spoken messages and nonverbal cues.

Goal 2-F: Effective and appropriate responses.

Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.

Goal 4-A: Clear and expressive speaking.

Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.

Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Assist patient with postural drainage

PERFORMANCE STANDARD Postural drainage initiates coughing and results in expectoration of sputum. Patient is assisted into postural drainage positions as ordered and for length of time ordered. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy for patient.
7. Watch for patient distress throughout procedure.
8. Provide patient with emesis basin and tissues.
9. Determine length of time patient is to remain in each drainage position.

For adult patient:

10. Seat patient in chair with head bent forward.

For child:

11. Seat patient in lap and lean patient's trunk backward at 30° angle.

For both adult and child:

12. Place towel to catch drainage or secretions.
13. Percuss over area between clavicle and scapulae using three index fingers flexed and held together.

For adult patient:

14. Assist patient to lie partly on left side and partly on abdomen on flat bed.

For small child:

15. Lean child forward on lap at 20° angle over pillow.

For both adult and child:

16. Percuss upper back on both sides between scapulae.
17. Assist patient to supine position.
18. Percuss upper chest below clavicle down to nipple line. NOTE: Do not percuss breasts of women.
19. Elevate foot of bed 15 inches.
20. Instruct patient to lie on right side.
21. Place pillows against patient's back and instruct patient to lean against pillows.

STEPS
(Cont.)

22. Percuss left side of chest between fourth and sixth rib.
    NOTE: For females, percuss beneath breast with heel of hand toward armpit.
23. Instruct patient to lie on left side.
24. Place pillows against patient's back and instruct patient to lean against pillows.
25. Percuss right side of chest between fourth and sixth rib.
    NOTE: For females, percuss beneath breast with heel of hand toward armpit.
26. Position bed flat.
27. Assist patient to lie on abdomen.
28. Percuss middle area of back on both sides of spine.

For adult patient:

29. Elevate foot of bed 18 inches.
30. Elevate patient's hips on pillows so that hips are higher than shoulders.

For small child:

31. Lie child on left or right side with head lowered 30°.

For both adult and child:

32. Reverse side-lie to percuss other side.
33. Percuss both sides over lower ribs but above stomach.

For adult patient:

34. Position bed flat.
35. Assist patient to side-lying position with hips elevated on pillows.

For small child:

36. Lie child on back with head elevated 30°.
37. Place pillows under affected side.

For both adult and child:

38. Percuss lower ribs.
39. Assist patient into prone position by elevating hips into jackknife position from knees to shoulders.
40. Percuss over lower ribs on both sides, close to spine.
    CAUTION: DO NOT PERCUSS OVER SPINE OR WHERE KIDNEYS LIE.
41. Leave patient in a safe and comfortable position.
42. Clean and put away equipment and supplies not in use.
43. Wash hands.
44. Record and report patient's tolerance of procedure and sputum production.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.

KNOWLEDGE (Cont.)	Position patient for treatment, including prone, supine, side-lying and jackknife positions. Explain the anatomy and physiology of the respiratory system. Watch for signs of patient discomfort. Use medical terminology to communicate with other health care workers. Make hospital bed, occupied or unoccupied. Move and turn patient who is in hospital bed. Observe results of treatment. Use facility system to record and report treatments.
ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. Respect the patient's right to know about and participate in treatment. Accept responsibility to do even distasteful nursing tasks thoroughly. In addition, refer to Employability Skills List.
SAFETY	Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it. Discontinue treatment and report any complications.
EQUIPMENT AND SUPPLIES	Emesis basin Pillows Tissues Towel
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 119.
ILLINOIS STATE GOALS FOR LEARNING	Physical Development and Health: Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Suction infant's respiratory passage with bulb syringe

PERFORMANCE STANDARD Infant's airway is patent. Procedure is reported and recorded as required.

STEPS

1. Scrub hands.
2. Position infant by holding infant with head down or turning infant's head to side.
3. Suction nose and mouth gently with bulb syringe.
4. Put infant on back.
5. Repeat suctioning procedure if necessary.
6. Ascertain that airway is clear.
7. Place infant in crib.
8. Report and record nursing care.

KNOWLEDGE

Wash hands aseptically.
Use aseptic technique.
Organize needed supplies.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Observe results of treatment.
Use facility system to record and report treatments.
Describe the anatomy of respiratory passages of infant.
Use bulb syringe for suctioning.
Hold an infant.

ATTITUDES

Realize organization prevents loss of time and patient discomfort and safety.
Communicate willing and matter-of-fact attitude.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY	Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put crib sides up before leaving patient unattended.
EQUIPMENT AND SUPPLIES	Bulb syringe
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 176.
ILLINOIS STATE GOALS FOR LEARNING	Physical Development and Health: Goal 1-F: Basic concepts of human growth and development during the following stages: prenatal, infancy, childhood, adolescence, adulthood and the aging. Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Goal 2-R: Signs and symptoms indicating the need for professional medical attention. Language Arts: Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences. Goal 4-A: Clear and expressive speaking.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Assist with turning, coughing and deep breathing

PERFORMANCE STANDARD Patient's position is changed at least every two hours. Patient is taking deep breaths and is coughing forcibly every two hours. Procedure and observations are reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy for patient.
7. Place patient in supine position with head elevated as high as condition will permit.
8. Support operative site if appropriate.
9. Instruct patient to take a deep breath and cough as forcibly as possible.
10. Instruct patient to continue to deep breathe and cough 3-5 times.
11. Change patient's position at least every two hours.
12. Leave patient in a safe and comfortable position.
13. Clean and put away equipment and supplies not in use.
14. Wash hands.
15. Record and report treatment and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Support operative site with pillows.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.

KNOWLEDGE (Cont.)

Move and turn patient who is in hospital bed.
Observe results of treatment.
Use facility system to record and report treatments.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it even though the patient is seemingly unconscious.
Discontinue treatment and report any complications.
Prevent the complications of surgery or bedrest by encouraging patient to move about and use all of lung capacity.

EQUIPMENT AND SUPPLIES

Tissues
Pillows

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 62.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-A: Immediate and long-term effects of exercise and lack of exercise on the circulatory, respiratory and muscular systems of the body.
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Language Arts:

- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Give vaginal douche

PERFORMANCE STANDARD Patient's vaginal canal is irrigated with prescribed solution with no solution remaining in canal at conclusion of procedure. Patient's perineum and bed linens are clean and dry. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy for patient.
7. Instruct patient to void, assisting patient to bathroom or providing bedpan as needed.
8. Warm solution under running hot water.
   NOTE: Test temperature on inner aspect of your wrist, ensuring that water is neither too hot or too cold.
9. Assemble solution container with tubing.
10. Clamp off tubing.
11. Pour solution into container.
12. Hang container on standard and place in lowest position.
13. Remove top bedding and drape patient.
14. Assist patient to back-lying position with hips higher than shoulders.
15. Place disposable underpad under buttocks.
16. Position patient on bedpan.
17. Put on gloves.
18. Open clamp to run some solution over perineal area separating labia with your left hand.
19. Insert irrigation tip 3-4 inches into vagina using downward and backward motion.
20. Rotate irrigation tip several times allowing prescribed amount of solution to enter vagina slowly.
21. Remove irrigation tip when container is almost empty.
22. Assist patient to sitting position.
23. Dry perineum with tissue.
24. Empty bedpan.
25. Leave patient in a safe and comfortable position.
26. Clean and put away equipment and supplies not in use.
27. Wash hands.
28. Record and report treatment and results.

KNOWLEDGE

- Read and interpret doctor's orders.
- Read and interpret assignment sheet.
- Read and interpret patient care plan.
- Describe the anatomy of the female reproductive system.
- Explain the purpose of the vaginal irrigation.
- Identify medications that may be given in a vaginal irrigation.
- Use facility procedure for positively identifying patient.
- Wash hands aseptically.
- Use communication skills to explain procedures to patient and family.
- Use aseptic technique.
- Organize needed supplies.
- Operate hospital bed.
- Assist patient in using bedpan.
- Position and drape patient for treatment.
- Watch for signs of patient discomfort.
- Use medical terminology to communicate with other health care workers.
- Make hospital bed, occupied or unoccupied.
- Move and turn patient who is in hospital bed.
- Observe results of treatment.
- Use facility system to record and report treatments.

ATTITUDES

- Respect patient's right to privacy.
- Respect patient's dignity.
- Realize organization prevents loss of time and patient discomfort and inconvenience.
- Empathize with patient's feelings about procedure.
- Communicate willing and matter-of-fact attitude.
- Respect the patient's right to know about and participate in treatment.
- In addition, refer to Employability Skills List.

SAFETY

- Explain safe temperature of item which is to be in contact with patient's skin.
- Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
- Use principles of body mechanics to prevent injury to patient and self.
- Prevent accidents by providing adequate assistance to patient as indicated by their condition.
- Put siderails up before leaving patient unattended.
- Place call light where patient can easily reach it.
- Discontinue treatment and report any complications.

EQUIPMENT AND SUPPLIES

Bedpan
Drape
Gloves
Standard
Prescribed solution
Tissues
Disposable underpad
Vaginal irrigation tray

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 98.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply topical ointment

PERFORMANCE STANDARD Affected area or wound is cleaned before treatment. The ointment matches order exactly. The treatment does not cause undue pain or skin damage.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble supplies.
6. Select topical ointment as ordered.
7. Compare label with order by reading three times:
   A. Before removing from shelf.
   B. Before applying.
   C. Before returning to shelf.
8. Cleanse area to receive treatment.
9. Apply ointment in thin coats with either a sterile tongue blade, spatula, or rubber gloves, as ordered.
10. Clean and put away equipment and supplies.
11. Leave patient in a safe and comfortable position.
12. Wash hands.
13. Record and report treatment and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Explain how this specific topical ointment is used and what the purpose of the ointment is.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.

KNOWLEDGE (Cont.)

Cleanse and protect patient's skin.
Use facility system in reporting and recording treatments.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Use gentle touch during treatments as mucous membranes are easily injured.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment, and report any complications.

EQUIPMENT AND SUPPLIES

Topical ointment as ordered
Applicator for ointment
Gloves
Soap
Water
Towel
Washcloth
Sterile cleansing supplies if ordered.

SOURCE OF ANALYSIS

V-TECS Catalog, Community Health Aide, Performance Objective 78.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

ILLINOIS
STATE GOALS
FOR
LEARNING
(Cont.)

Language Arts:

- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:

- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Insert suppository

PERFORMANCE STANDARD Rectal suppository is lubricated and inserted through the anal sphincter and guided into the rectum along the rectal wall a distance of about three inches. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble supplies.
6. Provide for privacy.
7. Adjust bed to nearly flat position, and lower siderail if necessary.
8. Fold bed linen back over hips to expose buttocks.
9. Unwrap covering of suppository, leaving it on wrapper.
10. Put on examining glove.
11. Lubricate suppository.
12. Expose patient's anus.
13. Ask patient to take a deep breath.
14. Slip suppository into anus, and guide it along the wall of rectum for approximately 3 inches.
    NOTE: Avoid pushing suppository into fecal mass.
15. Withdraw finger, and hold patient's buttocks tightly together for a few seconds.
16. Remove glove and place it on paper towel.
17. Discard disposable supplies.
18. Clean and put away equipment and supplies.
19. Leave patient in a safe and comfortable position.
20. Wash hands.
21. Record and report treatment and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.

KNOWLEDGE (Cont.)

Explain how this specific suppository is used and what the purpose of the suppository is.
Describe the anatomy of the rectum, anus and anal sphincter.
Organize needed supplies.
Operate hospital bed.
Position patient for treatment.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Cleanse and protect patient's skin.
Use facility system in reporting and recording treatments.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
Accept responsibility to do even distasteful nursing tasks thoroughly.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Use principles of body mechanics to prevent injury to patient and self.
Use gentle touch during treatments as mucous membranes are easily injured.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call light where patient can easily reach it.
Discontinue treatment, and report any complications.

EQUIPMENT AND SUPPLIES

Clean examining glove
Lubricant, water soluble
Paper towel
Suppository

SOURCE OF ANALYSIS

V-TECS Catalog, Nurse Aide/Orderly, Performance Objective, 103.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Mathematics:
- Goal 7-D: Ability to determine whether an estimate is a better alternative than an exact value.

Social Sciences:
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Give therapeutic bath

PERFORMANCE STANDARD Patient is assisted with type of bath as ordered. Patient is assisted back to room; linens are changed; treatment bath is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Check the tub and clean it if necessary.
7. Assist the patient to the tub.

For medicated bath:

8. Add medication, i.e., oatmeal, sodium bicarbonate, cornstarch, saline, mustard as ordered.
9. Assist patient into tub.
10. Pat skin dry after bath.

For relaxing bath:

11. Fill tub to cover entire body.
12. Assist patient into tub.
13. Time bath for 15-20 minutes.

For hot water bath:

14. Fill tub with water at 110°.
15. Assist patient into tub.

For whirlpool bath:

16. Attach mechanism to bathtub or use specially prepared tub.
17. Assist patient into tub.

For soaks:

18. Use solution with frequency and temperature of water as ordered.
19. Assist patient into tub.

For sitz bath:

20. Use folded bath blanket in tub on which patient may sit.
21. Use bathtub or sitz tub.
22. Assist patient into tub.

For all baths:

23. Hang the "occupied" sign on the door.
24. Check on the patient frequently.
25. Wash and dry patient's back.
26. Assist the patient as needed to get out of the tub.
27. Assist patient to dry.

STEPS
(Cont.)

28. Put clean gown on patient.
29. Assist patient back to room or bed.
30. Give patient a backrub if indicated.
31. Change linen on bed.
32. Clean and put away equipment and supplies in room and tub room.
33. Leave patient in a safe and comfortable position.
34. Wash hands.
35. Record and report treatment and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Wash hands aseptically.
Use communication skills to explain procedures to patient and family.
Use aseptic technique.
Explain how this specific therapeutic bath is used and what the purpose of the bath is.
Explain the supplies and equipment needed for each type of therapeutic bath.
Organize needed supplies.
Operate hospital bed.
Watch for signs of patient discomfort.
Use medical terminology to communicate with other health care workers.
Make hospital bed, occupied or unoccupied.
Cleanse and protect patient's skin.
Use bath thermometer to determine the temperature of water in tub.
Transfer and transport patient from bed to tub room and back to room.
Use facility system in reporting and recording treatments.
Observe results of treatment.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Realize organization prevents loss of time and patient discomfort and inconvenience.
Empathize with patient's feelings about procedure.
Communicate willing and matter-of-fact attitude.
Respect the patient's right to know about and participate in treatment.
In addition, refer to Employability Skills List.

SAFETY

Identify safe temperatures for water which contacts patient's skin.
Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.

SAFETY (Cont.)	Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it. Discontinue treatment, and report any complications.
EQUIPMENT AND SUPPLIES	Washcloth Towels Soap "Occupied" sign Medication if ordered Bath thermometer Bath blanket for sitz bath Backrub lotion Clean gown Clean linen
SOURCE OF ANALYSIS	Nursing Skills for Allied Health Services, Wood and Rambo, pp. 238-239.
ILLINOIS STATE GOALS FOR LEARNING	Mathematics: Goal 3-A: Measurement in various contexts using appropriate units. Goal 3-B: Estimation of measurements. Goal 3-D: Conversion of units within one system and from one system to another. Goal 7-D: Ability to determine whether an estimate is a better alternative than an exact value. Language Arts: Goal 1-A: Recognition, recall, and summarization of material read. Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose. Goal 2-A: Meaning of spoken messages. Goal 2-C: Inferences from spoken messages and nonverbal cues. Goal 2-F: Effective and appropriate responses. Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences. Goal 4-A: Clear and expressive speaking. Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting. Goal 6-D: English grammar.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Social Sciences:
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Providing Therapeutic Measures

TASK Apply antiembolism elastic stockings

PERFORMANCE STANDARD Both of patient's legs are measured and are fitted with appropriate size stockings. Left stocking is on left leg and right stocking is on right leg. Stitching is positioned according to manufacturer's instructions. Application of stockings is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble supplies.
6. Provide for privacy.
7. Expose patient's legs.
8. Measure calf circumference.
9. Measure length of leg from heel to back of knee.
10. Record measurements.
11. Measure other leg and record measurements if gross difference exists in size of legs.
    NOTE: Order two sizes of stockings if leg sizes differ.
12. Obtain stockings in measured size(s).
13. Remove stockings from container.
14. Identify left and right leg stockings.
15. Insert hand into stocking as far as heel.
16. Grasp center of heel and turn stocking inside out to heel.
17. Position stocking over foot and heel.
18. Pull body of stocking up around ankle, calf and thigh.
19. Repeat for other leg.
20. Position stitching of stocking as indicated in instructions enclosed with stockings.
21. Explain importance to patient that stockings not be folded down.
22. Remove and apply stockings every shift.
23. Check size of stockings on patient to assure proper fit.
24. Report and record size(s) and application of stockings.

KNOWLEDGE Read and interpret assignment sheet.
Read and interpret patient care plan.

KNOWLEDGE (Cont.)	Read and interpret doctor's orders. Use facility procedure for positively identifying patient. Wash hands aseptically. Use communication skills to explain procedures to patient and family. Use aseptic technique. Explain why antiembolism stockings are used. Organize needed supplies. Operate hospital bed. Position patient for treatment. Watch for signs of patient discomfort. Use medical terminology to communicate with other health care workers. Cleanse and protect patient's skin. Use facility system in reporting and recording treatments. Observe results of treatment. Measure using tape measure. Compare measurements and determine any significant difference. Read and interpret manufacturer's instructions.
ATTITUDES	Respect patient's right to privacy. Respect patient's dignity. Realize organization prevents loss of time and patient discomfort and inconvenience. Empathize with patient's feelings about procedure. Communicate willing and matter-of-fact attitude. Respect the patient's right to know about and participate in treatment. In addition, refer to Employability Skills List.
SAFETY	Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques. Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Put siderails up before leaving patient unattended. Place call light where patient can easily reach it. Discontinue treatment, and report any complications.
EQUIPMENT AND SUPPLIES	Elastic antiembolism stockings Stocking chart Manufacturer's instructions Tape measure
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 66.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:
- Goal 3-B: Selected principles of learning and motivation.

Mathematics:
- Goal 3-A: Measurement in various contexts using appropriate units.

TASK ANALYSIS
FOR
HEALTH OCCUPATIONS

CLUSTER: **NURSING**
OCCUPATION: **PRACTICAL NURSE (L.P.N.)**
Duty Area: Performing Diagnostic Measures

TASK ANALYSIS

OCCUPATION	Practical Nurse (L.P.N.)
DUTY AREA	Performing Diagnostic Measures
TASK	Assist physician/dentist in diagnostic procedure
PERFORMANCE STANDARD	Patient is prepared for procedure. Equipment and supplies are available as needed for procedure. Assistance is provided as needed by physician. Patient is provided emotional support throughout procedure. Procedure is reported and recorded as required.
STEPS	1. Verify diagnostic procedure. 2. Wash hands. 3. Organize required equipment and supplies. 4. Identify patient. 5. Prepare patient for procedure. 6. Open equipment and supplies as needed. 7. Hand equipment and/or supplies as needed. 8. Hold patient, if needed. 9. Reassure and comfort patient, as appropriate. 10. Clean or dispose of equipment and supplies after procedure. 11. Leave patient in safe and comfortable position. 12. Wash hands. 13. Report and record procedure.
KNOWLEDGE	Read and interpret doctor's orders. Read and interpret patient care plan. Identify reason for procedure. Select equipment and supplies for procedure. Use teaching/learning skills to explain procedure to patient. Position patient for procedure. Use medical and surgical aseptic technique. Anticipate physician's needs during procedure. Use communication skills to reassure and comfort patient as is appropriate during difficult or painful procedures. Use accepted methods to dispose of, clean and sterilize equipment and supplies. Use facility procedures to report and record procedure.

ATTITUDES

Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept that patient may need restraint due to inability to control self during painful or frightening procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patients, staff and families.
Assist patient who may need restraint in order to save them from further injury.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.

EQUIPMENT AND SUPPLIES

Equipment and supplies for specific procedure.

SOURCE OF ANALYSIS

Curriculum Models and Competencies, Associate Degree Nursing, North Carolina Department of Community Colleges, 1983.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-K: Behaviors which promote self-esteem without being destructive to self or others.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Social Sciences:
- Goal 3-B: Selected principles of learning and motivation.
- Goal 3-F: Development of oral and written communication.

Biological and Physical Sciences:
- Goal 3-A: Ethical practices which include:
    1. honesty and integrity in the recording and reporting of the results of scientific inquiry;
    2. disclosure, including open discussion of ideas, techniques and results;
    3. rights of subjects, humanness and respect for life.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Test patient's mental awareness

PERFORMANCE STANDARD Patient's mental awareness is assessed through simple conversation. Observations are reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Begin conversation with patient noting patient's responses.
4. Ask patient to respond to simple questions such as:
   A. "What is your name?"
   B. "Where do you live?"
   C. "Where are you now?"
5. Orient patient as necessary.
6. Record and report responses and changes in patient's awareness.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Use facility procedure for positively identifying patient.
Use aseptic technique.
Explain the implications for testing mental awareness for various physical conditions.
Explain the levels of consciousness.
Use medical terminology to communicate with other health care workers.
Use facility system to record and report observations.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the need for careful observation in regard to mental awareness for various conditions.
In addition, refer to Employability Skills List.

SAFETY

Prevent the spread of infection to patient, staff and families by using good handwashing and aseptic techniques.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Put siderails up before leaving patient unattended.
Place call signal where patient can easily reach it even though the patient is seemingly unconscious.

EQUIPMENT AND SUPPLIES

Patient's chart

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 40.

ILLINOIS STATE GOALS FOR LEARNING

Biological and Physical Sciences:
- Goal 4-A: Observation.
- Goal 4-B: Classification.
- Goal 4-C: Inference.
- Goal 4-D: Prediction.
- Goal 4-E: Measurement.
- Goal 4-F: Communication.
- Goal 4-G: Data collection, organization and interpretation.

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-V: Characteristics of mental health and mental illness.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION	Practical Nurse (L.P.N.)
DUTY AREA	Performing Diagnostic Measures
TASK	Assist with physical examination
PERFORMANCE STANDARD	Patient is undressed and draped for examination. Physician is assisted in examining patient as situation requires. Labeled specimens are sent to lab with lab requisition slip. Procedure is recorded and reported as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Label specimen containers:
   A. Patient's name
   B. Patient's identification number
   C. Nursing unit
   D. Patient's room number
   E. Date and time of specimen collection.
7. Attach label to specimen container.
8. Fill out lab requisition slip:
   A. Patient's name
   B. Patient's identification number
   C. Nursing unit
   D. Patient's room number
   E. Date and time of specimen collection
   F. Tests to be done
   G. Physician's name
   H. Designate STAT or ROUTINE.
9. Provide privacy for patient.
10. Direct patient to undress or assist patient in undressing.
11. Position and drape patient according to area of body being examined.
    NOTE: Female patient should be attended by female nurse during examination by male physician. Male patient should be attended by male nurse during examination by female physician.
12. Hand physician essential equipment.
13. Position examination light.
14. Support patient in specific position.
15. Receive specimens.
16. Leave patient in a safe and comfortable position.
17. Send labeled specimens to lab.

STEPS (Cont.)

18. Direct patient to dress or assist patient in dressing.
19. Clean and put away equipment and supplies not in use.
20. Wash hands.
21. Record and report procedure.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Position patient for procedure.
Use medical and surgical aseptic technique.
Anticipate physician's needs during procedure.
Use communication skills to reassure and comfort patient as is appropriate during difficult or painful procedures.
Use accepted methods to dispose of, clean and sterilize equipment and supplies.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept that patient may need restraint due to inability to control self during painful or frightening procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patients, staff and families.
Assist patient who may need restraint in order to save them from further injury.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Discontinue procedure and report any complications.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Drape
Label
Lab requisition slip
Ophthalmoscope
Otoscope
Pelvic examination tray and pap smear equipment as indicated
Percussion hammer
Rectal glove and lubricant
Specimen container
Sphygmomanometer
Tongue blade
Tuning fork

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 183.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Social Sciences:
- Goal 3-A: Selected theories of human physical development.
- Goal 3-B: Selected principles of learning and motivation.
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Collect timed urine specimen

PERFORMANCE STANDARD Patient and bed linens are clean and dry. Labeled bottle for urine collection is kept in cool place. Urine is collected at specified times. Labeled specimen is sent to lab with requisition slip. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Fill out specimen label:
   A. Patient's name
   B. Patient's identification number
   C. Nursing unit
   D. Patient's room number
   E. Date and time of collection.
7. Attach label to specimen container.
8. Fill out lab requisition slip:
   A. Patient's name
   B. Patient's identification number
   C. Nursing unit
   D. Patient's room number
   E. Date and time of specimen collection
   F. Tests to be done
   G. Physician's name
   H. Designate STAT or ROUTINE.
9. Provide privacy for patient.
10. Assist patient to use bedpan, urinal or commode as condition dictates.
    NOTE: Ambulatory patient collects specimen unaided.
11. Instruct patient to void.
12. Discard this urine.
13. Record starting time.
14. Instruct patient to void all subsequent urine into bedpan or urinal and to notify nursing staff when each specimen is provided.
15. Collect all urine voided thereafter in labeled gallon bottle.
    NOTE: Collected urine must be kept in cool place.
16. Instruct patient to void at end of timed period.

STEPS
(Cont.)

17. Add this urine to total collected.
18. Clean and put away equipment and supplies not in use.
19. Wash hands.
20. Leave patient in a safe and comfortable position.
21. Send labeled specimen to lab with completed requisition slip.
22. Record and report procedure.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Use aseptic technique.
Use accepted methods to dispose of, and clean equipment and supplies.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Explain anatomy and physiology related to urination.
Explain facility procedures for requisition and for sending specimen to lab.
Time procedures.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Supervise and teach unlicensed personnel regarding performance of diagnostic procedures.
Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patients, staff and families.
Put siderails up before leaving patient unattended.

SAFETY (Cont.)

Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Alert card
Bedpan, urinal, specimen pan or commode
Gallon bottle
Label
Lab requisition slip
Specimen container

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 151.

ILLINOIS STATE GOALS FOR LEARNING

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Mathematics:
- Goal 3-A: Measurement in various contexts using appropriate units.

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.

Social Sciences:
- Goal 3-B: Selected principles of learning and motivation.
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Collect clean catch urine specimen

PERFORMANCE STANDARD Patient and bed linens are clean and dry. Clean catch specimen is collected midstream in voiding from clean perineal area. Medical asepsis is maintained during procedure. Labeled specimen is sent to lab with lab requisition slip. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Fill out specimen label:
   A. Patient's name
   B. Patient's identification number
   C. Nursing unit
   D. Patient's room number
   E. Date and time of collection.
7. Fill out lab requisition slip:
   A. Patient's name
   B. Patient's identification number
   C. Nursing unit
   D. Patient's room number
   E. Date and time of specimen collection
   F. Tests to be done
   G. Physician's name
   H. Designate STAT or ROUTINE.
8. Provide privacy for patient.
9. Assist patient to bedpan, urinal, commode or toilet with specimen pan in place.
10. Put on disposable gloves.
11. Instruct patient to, or assist patient to expose urinary meatus.
12. Instruct patient to, or assist patient to cleanse area around urinary meatus, front to back with clean cotton ball or antiseptic wipe for each stroke.
13. Instruct patient to void.
14. Collect urine specimen.
    NOTE: First and last portion of urine is not collected, only the mid-stream.
15. Remove gloves.

STEPS (Cont.)

16. Leave patient in a safe and comfortable position.
17. Clean and put away equipment and supplies not in use.
18. Wash hands.
19. Attach label to specimen container.
20. Send labeled specimen to lab with completed requisition slip.
21. Record and report procedure and observations.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Position patient for procedure.
Use medical aseptic technique.
Use communication skills to reassure and comfort patient as is appropriate during difficult or embarrassing procedures.
Use accepted methods to dispose of or clean equipment and supplies.
Explain facility procedures for requisition and for sending specimen to lab.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Write legibly.
Explain anatomy and physiology related to urination.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.

SAFETY (Cont.)

Use aseptic technique to prevent infection among patients, staff and families.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Bedpan, urinal, specimen pan or commode
Cleansing agent
Cotton balls or antiseptic wipes
Disposable gloves
Label
Lab requisition slip
Sterile specimen container

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 150.

ILLINOIS STATE GOALS FOR LEARNING

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Mathematics:
- Goal 3-A: Measurement in various contexts using appropriate units.

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.

Social Sciences:
- Goal 3-B: Selected principles of learning and motivation.
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Collect routine urine specimen

PERFORMANCE STANDARD Patient and bed linens are dry. Labeled specimen is sent to lab with lab requisition slip. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Fill out specimen label:
   A. Patient's name
   B. Patient's identification number
   C. Nursing unit
   D. Patient's room number
   E. Date and time of collection.
7. Attach label to specimen container.
8. Fill out lab requisition slip:
   A. Patient's name
   B. Patient's identification number
   C. Nursing unit
   D. Patient's room number
   E. Date and time of specimen collection
   F. Tests to be done
   G. Physician's name
   H. Designate STAT or ROUTINE.
9. Provide privacy for patient.
10. Assist patient to commode, bedpan, urinal or toilet(with specimen pan in place) as condition dictates.
    NOTE: Ambulatory patient collects specimen unaided.
11. Instruct patient to void.
12. Collect urine specimen and pour into labeled specimen cup, measuring as indicated.
13. Empty remainder of urine into toilet.
14. Leave patient in a safe and comfortable position.
15. Clean and put away equipment and supplies not in use.
16. Wash hands.
17. Send labeled specimen to lab with completed requisition slip.
18. Record and report procedure and observations.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Position patient for procedure.
Use medical aseptic technique.
Use communication skills to reassure and comfort patient as is appropriate during difficult or embarrassing procedures.
Use accepted methods to dispose of or clean equipment and supplies.
Explain facility procedures for requisition and for sending specimen to lab.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Write legibly.
Explain anatomy and physiology related to urination.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patients, staff and families.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES	Bedpan, urinal, commode or toilet with specimen pan Label Lab requisition slip Specimen container
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 149.
ILLINOIS STATE GOALS FOR LEARNING	Language Arts: Goal 1-A: Recognition, recall, and summarization of material read. Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose. Goal 2-A: Meaning of spoken messages. Goal 2-C: Inferences from spoken messages and nonverbal cues. Goal 2-F: Effective and appropriate responses. Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences. Goal 4-A: Clear and expressive speaking. Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting. Goal 6-D: English grammar. Mathematics: Goal 3-A: Measurement in various contexts using appropriate units. Physical Development and Health: Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Social Sciences: Goal 3-B: Selected principles of learning and motivation. Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Collect 24-hour urine specimen

PERFORMANCE STANDARD Patient and bed linens are clean and dry. Labeled bottle for urine collection is kept in cool place. Urine is collected over 24-hour period. Labeled specimen is sent to lab with requisition slip. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Fill out specimen label:
   - A. Patient's name
   - B. Patient's identification number
   - C. Nursing unit
   - D. Patient's room number
   - E. Date and time of collection.
7. Attach label to specimen container.
8. Fill out lab requisition slip:
   - A. Patient's name
   - B. Patient's identification number
   - C. Nursing unit
   - D. Patient's room number
   - E. Date and time of specimen collection
   - F. Tests to be done
   - G. Physician's name
   - H. Designate STAT or ROUTINE.
9. Provide privacy for patient.
10. Assist patient to use bedpan, urinal, toilet with specimen pan or commode as condition dictates.
    NOTE: Ambulatory patient collects specimen unaided.
11. Instruct patient to void.
12. Discard this urine.
13. Record starting time.
14. Instruct patient to void all subsequent urine into bedpan or urinal and to notify nursing staff when each specimen is provided.
15. Collect all urine voided thereafter in labeled gallon bottle.
    NOTE: Collected urine must be kept in cool place.
16. Instruct patient to void at end of 24-hour period.

STEPS (Cont.)

17. Add this urine to total collected.
18. Clean and put away equipment and supplies not in use.
19. Wash hands.
20. Leave patient in a safe and comfortable position.
21. Send labeled specimen to lab with completed requisition slip.
22. Record and report procedure.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Use aseptic technique.
Use accepted methods to dispose of, and clean equipment and supplies.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Explain anatomy and physiology related to urination.
Explain facility procedures for requisition and for sending specimen to lab.
Time procedure.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patients, staff and families.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.

SAFETY (Cont.)	Use principles of body mechanics to prevent injury to patient and self. Prevent accidents by providing adequate assistance to patient as indicated by their condition. Label all specimens accurately.
EQUIPMENT AND SUPPLIES	Alert card Bedpan, urinal, specimen pan or commode Gallon bottle Label Lab requisition slip Specimen container
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 151.
ILLINOIS STATE GOALS FOR LEARNING	Language Arts: Goal 1-A: Recognition, recall, and summarization of material read. Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose. Goal 2-A: Meaning of spoken messages. Goal 2-C: Inferences from spoken messages and nonverbal cues. Goal 2-F: Effective and appropriate responses. Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences. Goal 4-A: Clear and expressive speaking. Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting. Goal 6-D: English grammar. Mathematics: Goal 3-A: Measurement in various contexts using appropriate units. Physical Development and Health: Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Social Sciences: Goal 3-B: Selected principles of learning and motivation. Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION	Practical Nurse (L.P.N.)
DUTY AREA	Performing Diagnostic Measures
TASK	Collect sputum specimen
PERFORMANCE STANDARD	Minimum of one teaspoon of sputum is collected from patient when patient first wakes in morning. Container is sterile and not contaminated. Labeled specimen is sent to lab with lab requisition slip. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy for patient.
7. Fill out specimen label:
    A. Patient's name
    B. Patient's identification number
    C. Nursing unit
    D. Patient's room number
    E. Date of collection.
8. Attach label to specimen container.
9. Fill out lab requisition slip:
    A. Patient's name
    B. Patient's identification number
    C. Nursing unit
    D. Patient's room number
    E. Date and time of specimen collection
    F. Tests to be done
    G. Physician's name
    H. Designate STAT or ROUTINE.
10. Place container at bedside.

Instruct patient to:

11. Collect specimen upon waking in morning.
12. Cough up sputum from lungs and bronchi.
13. Spit into container.
14. Call as soon as specimen is collected.

When patient has collected specimen:

15. Return to collect specimen.
16. Assist patient with oral hygiene.
17. Send labeled specimen to lab with completed requisition slip.
18. Leave patient in a safe and comfortable position.
19. Clean and put away equipment and supplies not in use.

STEPS (Cont.)

20. Wash hands.
21. Record and report procedure and characteristics of specimen.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Use medical aseptic technique.
Use communication skills to reassure and comfort patient as is appropriate during difficult or embarrassing procedures.
Use accepted methods to dispose of or clean equipment and supplies.
Use facility procedures for requisition and for sending specimen to lab.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Write legibly.
Explain anatomy and physiology related to respiratory system.
Describe sputum and how patient raises sputum.

ATTITUDES

Recognize that collecting a sputum specimen can be embarrassing for the patient.
Recognize that other patients may find the sounds and sight of coughing and expectorating upsetting and nauseating.
Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patient, staff and families.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Label
Lab requisition slip
Specimen container
Oral hygiene equipment and supplies

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 152.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.
- Goal 2-T: Causes and methods of preventing common communicable and noncommunicable diseases, including dental disease.

Biological and Physical Sciences:
- Goal 1-N: Relationship of structure to function.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION — Practical Nurse (L.P.N.)

DUTY AREA — Performing Diagnostic Measures

TASK — Collect stool specimen

PERFORMANCE STANDARD — Patient and bed linens are clean. Collected specimen is labeled and is sent to lab with lab requisition slip. Procedure is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy for patient.
7. Fill out specimen label:
    A. Patient's name
    B. Patient's identification number
    C. Nursing unit
    D. Patient's room number
    E. Date and time of collection.
8. Fill out lab requisition slip:
    A. Patient's name
    B. Patient's identification number
    C. Nursing unit
    D. Patient's room number
    E. Date and time of specimen collection
    F. Tests to be done
    G. Physician's name
    H. Designate STAT or ROUTINE.

Collect specimen from continent patient:

9. Provide bedpan, commode or toilet with specimen pan.
10. Instruct patient to call when defecation completed.
11. Return when called by patient.
12. Put on disposable gloves.
13. Transfer stool specimen to specimen container using tongue blade.
14. Wrap tongue blade in paper towel.

Collect specimen from incontinent patient:

15. Put on disposable gloves.
16. Use tongue blade to transfer specimen from linen to specimen container.
17. Cleanse patient.

Collect specimen from unconscious or constipated patient:

18. Put on disposable gloves.

STEPS
(Cont.)

19. Remove stool specimen manually.
20. Place specimen in container.

After collecting stool specimen:

21. Remove gloves.
22. Leave patient in a safe and comfortable position.
23. Clean and put away equipment and supplies not in use.
24. Wash hands.
25. Attach label to specimen container.
26. Send labeled specimen to lab with completed requisition slip.
    NOTE: Ova and parasite specimens must be delivered immediately.
27. Record and report procedure and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Position patient for procedure.
Use medical aseptic technique.
Use communication skills to reassure and comfort patient as is appropriate during difficult or embarrassing procedures.
Use accepted methods to dispose of or clean equipment and supplies.
Explain facility procedures for requisition and for sending specimen to lab.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Write legibly.
Explain anatomy and physiology related to elimination.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.

ATTITUDES (Cont.)

Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patient, staff and families.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Bedpan, commode or toilet with specimen pan
Disposable gloves
Label
Lab requisition slip
Paper towel
Specimen container
Tongue blades

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 148.

ILLINOIS STATE GOALS FOR LEARNING

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

Biological and Physical Sciences:
- Goal 1-N: Relationship of structure to function.

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Strain urine

PERFORMANCE STANDARD Patient and bed linens are clean and dry. Stones are saved and results of urine straining are reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy for patient.
7. Give patient a specimen cup.
8. Direct patient to void into specimen container.
9. Assist patient to bathroom or to use bedpan or urinal as condition indicates.
10. Pour urine through strainer.
11. Watch for any stones in strainer.
    NOTE: If stone is passed, save in container.
12. Leave patient in a safe and comfortable position.
13. Clean and put away equipment and supplies not in use.
14. Wash hands.
15. Record and report procedure and observations.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Use medical aseptic technique.
Use communication skills to reassure and comfort patient as is appropriate during difficult or embarrassing procedures.
Use accepted methods to dispose of or clean equipment and supplies.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.

KNOWLEDGE (Cont.)

Write legibly.
Explain anatomy and physiology related to urination.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patient, staff and families.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Bedpan, urinal, commode or toilet with specimen pan
Container
Specimen cup
Urine strainer

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 87.

ILLINOIS STATE GOALS FOR LEARNING

- Language Arts:
  - Goal 1-A: Recognition, recall, and summarization of material read.
  - Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
  - Goal 2-A: Meaning of spoken messages.
  - Goal 2-C: Inferences from spoken messages and nonverbal cues.
  - Goal 2-F: Effective and appropriate responses.
  - Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
  - Goal 4-A: Clear and expressive speaking.
  - Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
  - Goal 6-D: English grammar.
- Mathematics:
  - Goal 3-A: Measurement in various contexts using appropriate units.
- Physical Development and Health:
  - Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.
- Social Sciences:
  - Goal 3-B: Selected principles of learning and motivation.
  - Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Perform urine test for sugar and acetone

PERFORMANCE STANDARD Patient and bed linens are clean and dry. Test is done on second voided specimen unless patient cannot produce second specimen. Effects of Clinitest tablet, Tes-tape or Ketostix are compared with color chart. Results of test are reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Assist patient to bedpan, urinal, commode or toilet with specimen pan as indicated by condition.
   NOTE: Ambulatory patient collects specimen unaided.
7. Provide privacy for patient.
8. Instruct patient to void.
9. Save urine in case patient cannot void second time.
10. Give patient liquids to drink.
11. Instruct patient to void for second specimen.

For Clinitest method:

12. Drop 5 drops of urine into test tube with eyedropper.
13. Rinse eyedropper.
14. Drop 10 drops of water into test tube.
15. Rotate test tube between fingers to mix urine and water.
16. Drop one Clinitest tablet into test tube without touching tablet with fingers.
17. Close bottle tightly.
18. Shake tube gently after 15 seconds.
19. Compare with Clinitest color chart.

For Tes-tape method:

20. Remove 1 1/2 inches of Tes-tape from dispenser.
21. Dip tape end into urine specimen and remove immediately or drop urine on Tes-tape.
22. Wait 60 seconds.
23. Compare tape with color chart.

For Ketostix method:

24. Remove one Ketostix from bottle.
25. Close bottle tightly.
26. Dip tip of Ketostix into urine.
27. Tap on side of container to remove excess.
28. Remove Ketostix.

STEPS (Cont.)

29. Wait 15 seconds.
30. Compare Ketostix to color chart.

After tests:

31. Leave patient in a safe and comfortable position.
32. Clean and put away equipment and supplies not in use.
33. Wash hands.
34. Record and report procedure and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Use medical aseptic technique.
Use communication skills to reassure and comfort patient as is appropriate during difficult or embarrassing procedures.
Use accepted methods to dispose of or clean equipment and supplies.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Write legibly.
Explain anatomy and physiology related to urination, renal and endocrine function.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patients, staff and families.
Put siderails up before leaving patient unattended.

SAFETY (Cont.)

Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Bedpan, urinal, commode or toilet with specimen pan
Specimen container
Clinitest tablet or Tes-tape and Ketostix
Eyedropper
Water
Sugar and acetone color charts
Test tube

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 153.

ILLINOIS STATE GOALS FOR LEARNING

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Mathematics:
- Goal 3-A: Measurement in various contexts using appropriate units.

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.

Social Sciences:
- Goal 3-B: Selected principles of learning and motivation.
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Measure specific gravity of urine

PERFORMANCE STANDARD Patient and bed linens are clean and dry. Specific gravity is measured from dark area of urinometer. Reading is reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy for patient.
7. Collect routine urine specimen.
8. Draw up urine in eyedropper.
9. Deposit one drop urine onto designated area of urinometer.
10. Close instrument.
11. Look through eyepiece of instrument.
12. Note number where dark area ends.
13. Clean instrument and eyedropper.
14. Return equipment to storage.
15. Leave patient in a safe and comfortable position.
16. Wash hands.
17. Record and report procedure and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Use medical aseptic technique.
Use communication skills to reassure and comfort patient as is appropriate during difficult or embarrassing procedures.
Use accepted methods to dispose of or clean equipment and supplies.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.

KNOWLEDGE (Cont.)

Write legibly.
Explain anatomy and physiology related to urinary system.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patient, staff and families.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Bedpan, urinal, commode or specimen pan
Eyedropper
Specimen container
Urinometer

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 154.

ILLINOIS STATE GOALS FOR LEARNING

Social Sciences:
- Goal 3-B: Selected principles of learning and motivation.
- Goal 3-F: Development of oral and written communication.

Mathematics:
- Goal 3-A: Measurement in various contexts using appropriate units.

ILLINOIS STATE GOALS FOR LEARNING (Cont.)

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Test for ketones

PERFORMANCE STANDARD Patient and bed linens are clean and dry. Test is done on second voided specimen unless patient cannot produce second specimen. Effects of Acetest tablet or Ketostix are compared with color chart. Results of test are reported and recorded as required.

STEPS

1. Verify order.
2. Verify patient's identity.
3. Explain procedure to patient.
4. Wash hands.
5. Assemble equipment and supplies.
6. Provide privacy for patient.
7. Collect second voided urine specimen.

Test urine using Acetest:

8. Place Acetest tablet on paper towel.
   NOTE: Use bottle cap, not fingers to move tablet.
9. Replace cap on bottle tightly.
10. Rinse the eyedropper with water.
11. Draw some of the urine into eyedropper.
12. Drop one drop of urine onto the tablet.
13. Wait 30 seconds.
14. Compare the tablet with the color chart.

Test urine using Ketostix:

15. Remove one Ketostix from bottle.
16. Close bottle tightly.
17. Dip tip of Ketostix into urine.
18. Tap on side of container to remove excess.
19. Remove Ketostix.
20. Wait 15 seconds.
21. Compare Ketostix to color chart.
22. Read the result that corresponds with the color match.

After tests:

23. Leave patient in a safe and comfortable position.
24. Clean and put away equipment and supplies not in use.
25. Wash hands.
26. Record and report procedure and results.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan.

KNOWLEDGE (Cont.)

Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to patient.
Use medical aseptic technique.
Use communication skills to reassure and comfort patient as is appropriate during difficult or embarrassing procedures.
Use accepted methods to dispose of or clean equipment and supplies.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Write legibly.
Explain anatomy and physiology related to urinary system.
Compare color charts and determine similarities.

ATTITUDES

Respect patient's right to privacy.
Respect patient's dignity.
Empathize with patient regarding diagnostic procedure.
Accept the importance of performing procedures efficiently and quickly.
Value patient comfort, safety and cooperation.
Value cost containment and prepare only what is needed for procedure.
Accept need to use terminology patient understands.
Accept need to do distasteful nursing tasks thoroughly.
Accept patient's need for privacy and possible resistance to accepting assistance.
Value patient's need to comprehend their role in collecting specimen.
Accept need to be honest in regard to accurately carrying out procedure.
In addition, refer to Employability Skills List.

SAFETY

Use facility procedure to positively identify patient.
Use aseptic technique to prevent infection among patients, staff and families.
Put siderails up before leaving patient unattended.
Place call signal where patient can reach it.
Use principles of body mechanics to prevent injury to patient and self.
Prevent accidents by providing adequate assistance to patient as indicated by their condition.
Label all specimens accurately.

EQUIPMENT AND SUPPLIES

Bedpan, urinal, commode or toilet with specimen pan
Specimen container
Acetest tablet
Ketostix

EQUIPMENT AND SUPPLIES (Cont.)

Eyedropper
Water
Color charts
Paper towel

SOURCE OF ANALYSIS

V-TECS Catalog, Licensed Practical Nurse, Performance Objective 153.
V-TECS Catalog, Nurse Aide/Orderly, Performance Objective 45.

ILLINOIS STATE GOALS FOR LEARNING

Language Arts:
- Goal 1-A: Recognition, recall, and summarization of material read.
- Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.
- Goal 2-A: Meaning of spoken messages.
- Goal 2-C: Inferences from spoken messages and nonverbal cues.
- Goal 2-F: Effective and appropriate responses.
- Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.
- Goal 4-A: Clear and expressive speaking.
- Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.
- Goal 6-D: English grammar.

Mathematics:
- Goal 3-A: Measurement in various contexts using appropriate units.

Physical Development and Health:
- Goal 1-G: Basic human anatomy and physiology as it relates to health and disease.

Social Sciences:
- Goal 3-B: Selected principles of learning and motivation.
- Goal 3-F: Development of oral and written communication.

TASK ANALYSIS

OCCUPATION Practical Nurse (L.P.N.)

DUTY AREA Performing Diagnostic Measures

TASK Weigh and measure infant

PERFORMANCE STANDARD Infant's head is supported during procedure. Infant's weight and length are measured; and measurements are reported and recorded as required.

STEPS

1. Verify order.
2. Verify infant's identity.
3. Explain procedure to parent.
4. Wash hands.
5. Assemble equipment and supplies.
6. Place protector pad on scales.
7. Remove infant's clothing.
8. Place infant flat on scales.
   CAUTION: Infant's head must be supported at all times.
9. Note infant weight.
10. Measure infant from head to feet.
11. Replace infant in crib, rewrapping with blanket.
12. Report and record weight and length measurements.

KNOWLEDGE

Read and interpret doctor's orders.
Read and interpret assignment sheet.
Read and interpret patient care plan
Wash hands aseptically.
Use medical terminology to communicate with other health care workers.
Identify reason for procedure.
Select equipment and supplies for procedure.
Use communication skills to explain procedure to parent.
Position patient for procedure.
Use medical aseptic technique.
Use accepted methods to dispose of or clean equipment and supplies.
Use facility system to record and report observations.
Use facility procedures to report and record procedure.
Write legibly.
Balance scale with protector pad in place as weight of pad can alter accuracy of small infant's weight significantly.
Read and convert pounds and kilograms.
Read and convert inches and centimeters.
Balance scale.

KNOWLEDGE (Cont.)	Read scale. Hold infant. Dress and undress infant.
ATTITUDES	Accept the importance of performing procedures efficiently and quickly. Value patient comfort, safety and cooperation. Value cost containment and prepare only what is needed for procedure. Accept need to use terminology parent understands. Accept need to be honest in regard to accurately carrying out procedure. In addition, refer to Employability Skills List.
SAFETY	Use facility procedure to positively identify patient. Use aseptic technique to prevent infection among infant, staff and families. Put crib sides up before leaving infant unattended. Safeguard infant by remaining directly in front while weighing. Handle infant safely.
EQUIPMENT AND SUPPLIES	Protector pad Scales Tape measure
SOURCE OF ANALYSIS	V-TECS Catalog, Licensed Practical Nurse, Performance Objective 177.
ILLINOIS STATE GOALS FOR LEARNING	Mathematics: Goal 3-A: Measurement in various contexts using appropriate units. Goal 3-D: Conversion of units within one system and from one system to another. Goal 3-E: Application of selected measurement systems, instruments, and techniques. Goal 7-D: Ability to determine whether an estimate is a better alternative than an exact value. Physical Development and Health: Goal 1-F: Basic concepts of human growth and development during the following stages: prenatal, infancy, childhood, adolescence, adulthood and the aging. Goal 1-G: Basic human anatomy and physiology as it relates to health and disease. Goal 2-R: Signs and symptoms indicating the need for professional medical attention.

ILLINOIS
STATE GOALS
FOR
LEARNING
(Cont.)

Language Arts:

Goal 1-A: Recognition, recall, and summarization of material read.

Goal 1-C: Reading for various purposes and identification of text to accomplish each purpose.

Goal 2-A: Meaning of spoken messages.

Goal 2-C: Inferences from spoken messages and nonverbal cues.

Goal 2-F: Effective and appropriate responses.

Goal 3-A: Use of appropriate language and style in writing for a variety of purposes and audiences.

Goal 4-A: Clear and expressive speaking.

Goal 4-D: Use of appropriate language and nonverbal cues for the topic, audience, and setting.

Goal 6-D: English grammar.